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FORM APPROVED
OMB NO. 0938-0391

EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G161	A. BUILDING _____ B. WING _____	06/20/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRYSALLIS	3765 FIRST STREET, SE WASHINGTON, DC 20020

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W 000	INITIAL COMMENTS A recertification survey was conducted from June 18, 2007 thru June 20, 2007. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a resident population of six males with various disabilities. The survey findings were based on observations in the group home, interviews with residential, nursing and administrative staff. Review of records, including investigations of unusual incidents was also conducted. The survey findings determined that the facility failed to substantially comply with the Condition of Participation in Health Care Services.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, interviews and review of records, the facility's governing body provided general operating direction over the facility, except in the following areas: The finding includes: The governing body failed to ensure the maintenance of the facility's environment, as evidenced by: a. Loose frame on wooden chair b. Carpet has loose strips in television area c. Carpet has loose strips at the doorway of Client #3's bedroom	W 104	In response to W 104, the facility says as follows: a. Loose frame on wooden chair has been fixed b. Loose carpet strips in television area has been fixed and will further be maintained until replaced completely c. Loose carpet strips at the doorway of client #3's bedroom has been fixed and will be further be maintained until replaced completely.	6/21/07 and ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jean S. Wilson — TITLE: President/CEO — (X6) DATE: 07-24-07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 d. Torn areas on the armrests of four upholstered chairs along the wall between teevision area and living room e. Chipped tile on raised area of large hallway shower room f. Lamp shade torn/bent in Client #3's room	W 104		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observations, staff interview, and record review, the facility failed to effectively monitor each client's day program to assure that the needs were met for one of three clients in the sample. (Client #3) The finding includes: Observation during the lunch mealtime on June 18, 2007 at approximately 11:40 AM revealed that Client #3 was served his prescribed diet in a divided plate and he was holding a built-up angled spoon in his right hand. Further observation revealed that Client #3 coughed twice when drinking from the paper cup. In an interview with the day program staff on June 18, 2007 at approximately 11:50 AM it was acknowledged that Client #3 used a paper cup instead of an opened handled spout mug during mealtime. Further interview revealed that Client #3 did have an opened handled spout mug to use at the day program during mealtime. Review of the	W 120	As response to W 120, the facility say as follows: a. The Day Program was fully aware that client #3 uses an open handled spout mug. b. Client continues to use an open handled spout mug in the day program. The QMRP will further have a case conference with the day program to ensure that the use of the mug is not skipped any day.	ongoing 7/26/07

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W 120	Continued From page 2 Individual Support Plan (ISP) dated June 13, 2006 on June 19, 2007 at approximately 9:25 AM revealed that it was recommended that Client #3 utilize an opened handled spout mug during mealtime. Review of the Speech Therapist assessment dated May 28, 2006 on June 19, 2006 at approximately 9:50AM revealed a recommendation to monitor client for rapid eating. There was no evidence Client #3 used an opened handled spout mug as recommended by the ISP in the day program.	W 120		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, and interviews the facility failed to demonstrate how the rights of all clients were protected and failed to allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States for six of six clients in the facility. The finding includes: During the survey conducted June 18-20, 2007, there was a voice alarm that rang each time one of the exit doors was opened. Interview with the Administrator on June 19, 2007 at approximately at 3:00 PM revealed that the door voice alarm was to prevent intruders from entering the facility. Further interview revealed that the door voice	W 125	As response to W 125, the facility says that the Human Rights Committee of the Company review the door alarm system cited herein and decides whether to approve the door alarm system or not .The decision of the committee will be upheld and implemented to ensure adequate protection of the rights of the individuals being served.	7/27/07

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W 125	Continued From page 3 alarm system had not been approved by the Human Rights Committee (HRC).	W 125		
W 126	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the clients' right to be taught to manage their financial affairs to the extent of their capabilities for one of three clients in the sample. (Client #3) The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on June 19, 2007 at approximately 4:15PM revealed that Client #3 had not received a comprehensive money management assessment that outlined his current skills and specific needs in this area. Review of Client #3's Individual Support Plan (ISP) dated June 13, 2006, at approximately 4:20PM on April 19, 2007 confirmed the QMRP's statement. There was no evidence that Client #3 was taught to manage his finances to the extent of his capability.	W 126	As a response to W 126, the facility says as follows: a. Client # 3 has received a comprehensive money management assessment. b. The QMRP will ensure effective implementation of any program based on the assessment for client #3. c. Aggressive quality assurance will be provided henceforth to ensure that client # 3 and other individuals being served receive money management assessments timorously to ensure continuous protection of the rights of the individuals to manage their financial affairs to best of their capabilities.	7/10/07 ongoing 7/10/07 and ongoing
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.	W 159		

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W 159	Continued From page 4 This STANDARD is not met as evidenced by: Based on interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services for two of three clients in the sample. (Client #1 and Client #3) The findings include: 1. The QMRP failed to ensure that the direct care staff allowed Client #1 to use the appropriate adaptive feeding equipment at mealtime as evidenced by: Dinner observation on June 18, 2007 at approximately 6:05 PM revealed that Client #1 was using a bulit-up handled teaspoon in his right hand to eat his prescribed diet from a scoop plate. In an interview with the client's one to one on June 18, 2007 at approximately 6:15 PM it was acknowledged that Client #1 used a scoop plate instead of a plate guard during mealtime. Review of the OT assessment dated November 11, 2006 on June 19, 2007 at approximately 12:55 PM revealed a recommendation for Client #1 to utilize a plate guard. Review of the Individual Support Plan (ISP) dated November 14, 2006 on June 8, 2007 at approximately 12:45 PM revealed a recommendation that Client #1 utilize a plate guard during mealtime. There was no evidence Client #1 used a plate guard as recommended by the ISP. 2. The QMRP failed to coordinate services with Client #3's day program to ensure the use of adaptive equipment during mealtimes as evidenced by:	W 159	In response to W 159(1), the facility says as follows: 1. Although the purpose of the use of a plate guard is to prevent spillage and a scoop plate also prevents spillage, the direct care staff has been retrained to ensure that client #1 uses only plate guard during mealtime until the OT reviews the assessment. The QMRP and the Manager will aggressively monitor the staff to ensure consistent compliance with this protocol. 2. As response to W 159(2), the facility say as follows: a. The Day Program was fully aware that client #3 uses an open handled spout mug. b. Client continues to use an open handled spout mug in the day program. The QMRP will further have a case conference the day program to ensure that there is no repeat of the deficiency and or other concerns. 3. As a response to W. 159(3) the facility says the direct care staff has been in serviced to ensure that client # 3 and other individuals being served use the appropriate and recommended adaptive equipments during mealtime. The QMRP and the House Manager will monitor the staff to ensure full compliance with the mealtime protocol for all the individuals being served in the facility.	6/27/07 and ongoing ongoing 7/26/07 6/27/07 and ongoing ongoing

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W 159	Continued From page 5 Observation during the lunch mealtime on June 18, 2007 at approximately 11:40 AM revealed that Client #3 was served his prescribed diet in a divided plate and he was holding a built-up angled spoon in his right hand. Further observation revealed that Client #3 coughed twice when drinking from the paper cup. In an interview with the day program staff on June 18, 2007 at approximately 11:50 PM it was acknowledged that Client #3 used a paper cup instead of an opened handled spout mug during mealtime. Further interview revealed that Client #3 did have an opened handled spout mug to use at the day program during mealtime. Review of the Individual Support Plan (ISP) dated June 13, 2006 on June 19, 2007 at approximately 9:25 AM revealed that it was recommended that Client #3 utilize an opened handled spout mug during mealtime. Review of the Speech Therapist assessment dated May 28, 2006 on June 19, 2006 at approximately 9:50AM revealed a recommendation to monitor client for rapid eating. There was no evidence Client #3 used an opened handled spout mug as recommended by the ISP in the the day program. 3. The QMRP failed to ensure that the direct care staff allowed Client #3 to use the appropriate adaptive feeding equipment at mealtime as evidenced by: Observation during the dinner mealtime on June 18, 2007 at approximately 6:05 PM revealed that Client #3 was served his prescribed diet in a divided plate and he was holding a built-up angled spoon in his right hand. Further observation revealed that Client #3 coughed twice when drinking from a standard type cup . In an interview	W 159		

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W 159	Continued From page 6 with the direct care staff on June 18, 2007 at approximately 6:12 PM it was acknowledged that Client #3 used a standard cup instead of an opened handled spout mug during mealtime. Review of the Individual Support Plan (ISP) dated June 13, 2006 on June 19, 2007 at approximately 9:25 AM revealed that it was recommended that Client #3 utilize an opened handled spout mug during mealtime. Review of the Speech Therapist assessment dated May 28, 2006 on June 19, 2006 at approximately 9:50AM revealed a recommendation to monitor client for rapid eating. There was no evidence Client #3 used an opened handled spout mug as recommended by the ISP in the facility. 4. The QMRP failed to ensure that all staff had been effectively trained to implement emergency measures for six of six clients in the facility as evidenced by: Interview with the QMRP on June 19, 2007 at approximately 1:45 PM revealed that all staff would be trained in CPR by June 22, 2007. Record review on June 19, 2007 at approximately 1:50 PM revealed that nine out of twenty staff did not have current CPR certification. There was no documented evidence that all direct care staff had CPR training and current CPR certifications. 5. The QMRP failed to ensure that all staff had been effectively trained to implement emergency measures for six of six clients in the facility as evidenced by: Interview with the QMRP on June 19, 2007 at approximately 1:55 PM revealed that all staff would be trained in First Aid by June 22, 2007. Record review on June 19, 2007 at approximately	W 159	W159 483.420 (a) QMRP #4 & 5: Staff training had indeed expired and re-training in CPR and First Aid had been scheduled with an outside qualified trainer. However, each shift did have coverage by a staff person whose certification had not expired. Staff have attended/ passed CPR and First Aid training.	7/10/07

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W 159	Continued From page 7 2:00 PM revealed that seven out of twenty staff did not have current First Aid certification. There was no documented evidence that all direct care staff had First Aid training and current First Aid certifications. 6. The QMRP failed to ensure that Client #3 had received a comprehensive money management assessment that outlined his current skills and specific needs as evidenced by: Interview with the Qualified Mental Retardation Professional (QMRP) on June 19, 2007 at approximately 4:15PM revealed that Client #3 had not received a comprehensive money management assessment that outlined his current skills and specific needs in this area. Review of Client #3's Individual Support Plan (ISP) dated June 13, 2006, at approximately 4:20PM on April 19, 2007 confirmed the QMRP's statement. There was no evidence that the Client #3 was taught to manage his finances to the extent of his capability. 7. The QMRP failed to ensure that Client #3 had a shower chair as recommended by the Occupational Threapist (OT) as evidenced by: During an environmental observation of all client areas on June 19, 2007 at approximately 10:00AM revealed that there was not a shower chair in the facility for Client #3 to utilize during bathtime. In an interview with the QMRP on June 19, 2007 at approximately 10:15 AM it was acknowledged that Client #3 did not have a shower chair. Review of Client #3's OT assessment dated May 20, 2006, at approximately 10:30AM on June 19, 2007 There was no evidence that the Client #3 had a a	W 159	As a response to W 159(6), the facility says as follows: a. Client # 3 has received a comprehensive money management assessment. b. The QMRP will ensure effective implementation of any program based on the assessment for client #3. c. Aggressive quality assurance will be provided henceforth to ensure that client # 3 and other individuals being served receive money management assessments timorously to ensure continuous protection of the rights of the individuals to manage their financial affairs to best of their capabilities. W159 #7: Client #3 has the use of a built-in shower bench, making an additional shower chair redundant, and reducing bathing space. Prior to the home's relocation to this facility, a shower chair was utilized, and then discarded after our move. The purpose of using a "shower chair" is for the person to sit safely while bathing; the shower bench facilitates this purpose.	7/10/07 ongoing 7/10/07 and ongoing

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W 159	Continued From page 8 shower chair as recommended by the OT.	W 159		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to effectively train staff to implement emergency measures for six of six clients in the facility. (Clients #1, #2, #3, #4, 5 and 6) The findings include: 1. Interview with the QMRP on June 19, 2007 at approximately 1:45 PM revealed that all staff would be trained in CPR by June 22, 2007. Record review on June 19, 2007 at approximately 1:50 PM revealed that nine out of twenty staff did not have current CPR certification. There was no documented evidence that all direct care staff had CPR training and current CPR certifications. 2. Interview with the QMRP on June 19, 2007 at approximately 1:55 PM revealed that all staff would be trained in First Aid by June 22, 2007. Record review on June 19, 2007 at approximately 2:00 PM revealed that seven out of twenty staff did not have current First Aid certification. There was no documented evidence that all direct care staff had First Aid training and current First Aid certifications.	W 192	W192 483.430 (e) (2) Staff Training Program #1 & #2: Staff training had indeed expired and re-training in CPR and First Aid had been scheduled with an outside qualified trainer on the best available date. However, each shift did have coverage by a staff person whose certification had not expired. Staff have attended/ passed CPR and First Aid training.	7/10/07
W 212	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the presenting problems and disabilities	W 212		

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W 212	Continued From page 9 and where possible, their causes. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that one of three clients in the sample who was receiving psychotropic medications had a psychiatric assessment. (Client #3). The findings include: Observation of the evening medication administration on June 18, 2007, at approximately 4:35 PM, revealed Client #2 received Revia 50 mg and Zyprexia 10mg by mouth. Interview with the nursing staff on June 18, 2007, at approximately 4:40 PM, revealed that the medication was prescribed for behavior management. Review of the client's physicians orders dated May 31, 2007, on June 18, 2007 at approximately 11:15 AM, revealed that Revia 50 mg and Zyprexia 10mg by mouth twice a day was incorporated in a Behavior Support Plan (BSP) dated September 20, 2006, to address behaviors associated with physical aggression, self-injurious behavior, PICA, tantrumming and clothes tearing. Review of Client #2's medical evaluation dated March 29, 2007, on June 19, 2007 at approximately 11:20 AM, revealed that the psychotropic medications were prescribed to address behaviors associated with a diagnosis of Atypical Psychosis . Review of Client #2's medical record on May 16, 2007, at approximately 11:25 AM, revealed no documented evidence of a psychiatric assessment.	W 212	In response to W 212, the facility says as follows: a. Client # 3 does not receive any psychotropic drug, but client#2 does. Client # 2 has a comprehensive psychiatric assessment as desired and is in the file.	7/14/07
W 252	483.440(e)(1) PROGRAM DOCUMENTATION	W 252		

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W 252	Continued From page 10 Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that each client's Individual Program Plan (IPP) objectives are documented consistently and accurately for one of three clients in the sample.(Client #1) The finding includes: Client #1 was observed on June 18, 2007 at approximately 4:40PM, to become very physically aggressive and knocked a filled medication cup out of the Licensed Practical Nurses' (LPNs) hands. Review of Client #1's Behavioral Support Plan (BSP) dated December 21, 2006 on June 19, 2007 at approximately 12:50PM revealed that staff is to document on the data collection form to track incidents of Client#1's physical aggression towards self and others and throwing objects. Further record review revealed that staff was to document the targeted behaviors on the Antecedent Behavior Consequence (ABC) charts. On June 19, 2007 at approximately 4:20PM the review of the data chart revealed that Client #1 did not exhibit any targeted behaviors on June 18, 2007. There was no evidence that the data had been collected in accordance with the BSP for Client #1, which was necessary for a functional assessment of the client's progress.	W 252	In response to W 252, the facility says as follows: a. The one to one staff of client #1 and other staff have been retrained to ensure complete and consistent documentation of behavior incidents of client #1 and indeed other individuals being served at all times. The QMRP and the House Manager will continue to monitor the staff to ensure complete and consistent collection of data for behavior and other programs.	6/27/07 and ongoing Ongoing
W 310	483.450(e)(1) DRUG USAGE The facility must not use drugs in doses that	W 310		

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W 310	Continued From page 11 interfere with the individual client's daily living activities. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that medication administered for behavior management does not interfere with the daily living activities for one of three clients in the sample. (Client #1). The finding includes: 1. Observation of Client #1 on June 19, 2007 approximately between 12:45PM- 2:30PM revealed that the client appeared to be drifting in and out of sleep during that period of time as he laid on the couch in the living room. Further observation revealed that with several physical/verbal prompts the client was able to get up and go to the bathroom with his one to one staff member. Interview with the Administrator on June 19, 2007 at approximately 2:15PM revealed that they did not want to awaken the client because the facility wanted the psychiatrist to observe how Client #1 was excessively sleeping when he came to the psychotropic review meeting that was scheduled that day. There was no documented evidence to substantiate that medication administered did not interfere with the clients' daily living activities. [Note: The psychiatrist did not come to the facility for the planned psychotropic review meeting on June 19, 2007] 2. Cross refer to W332.1 and W331.1. Review of an unusual incident report dated June 20, 2007 at approximately 10:00AM revealed that Client #1	W 310	W310 483.450 (e)(1) Drug Usage #1: Client #1 was actively being medically evaluated for the sedated behavior which began prior to the survey date by his primary physician after the neurologist introduced a new medication to Client #1's drug regime. The suspected offending drug was held pending further evaluation and follow up. #2: The continued sedation prompted more immediate evaluation by another medical body to rule out more ominous underlying reasons for the behavior that were not mediation related. Nothing was found during the emergency room evaluation. Client #1 was actively being medically evaluated for the sedated behavior which began prior to the survey date by his primary physician after the neurologist introduced a new medication to Client #1's drug regime. The suspected offending drug was held pending further evaluation and follow up.	

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W 310	Continued From page 12 was observed sleeping on the couch when LPN #2 arrived on duty for medication pass at approximately 7:45AM. Client #1 appeared too drowsy at the time of medication pass and morning medications were not administered (Topamax 300mg, Revia 50 mg, Thorazine 400mg and Clarinex 5mg by mouth). Client #1 was transported to the emergency room for evaluation of excessive sleepiness at 9:05AM. Interview with LPN #2 and review of the Medication Administration Record (MAR) on June 20, 2007 at approximately 10:15AM revealed that Client #1 was administered Topamax 300mg, Revia 50 mg, Thorazine 400mg by mouth at 6:00PM and Klonopin 4 mg by mouth at bedtime on June 19, 2007. There was no documented evidence to substantiate that medication administered did not interfere with the clients' daily living activities. 3. Interview with the Director of the day program on June 21, 2007 at approximately 11:45 AM, revealed that on November 1, 2006 and on November 20, 2006 the facility was informed that Client#1 was observed to sleep from the time he arrived at the day program until around lunch time (11:00 AM-11:30 AM) and sometimes would fall asleep while eating his lunch. Further interview revealed that Client #1 last attended day program on June 7, 2007 and will need to be medically cleared before returning to the day program. Review of a psychotropic review document dated November 20, 2006 on June 20, 2007 at approximately 1:35PM revealed that "some sedation reported by day program". Further review psychotropic review document revealed that Topamax 400mg twice a day by mouth was decreased to Topamax 300mg twice a day by mouth.	W 310	#3: Reports of sleeping in November 2006: sedation significantly reduced with medication reduction.	

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W 310	Continued From page 13 [Note: The Primary Care Physician (PCP) has not medically cleared Client #1 to attend the day program] 4. Interview with LPN #2 and review of an AIMS assessment dated December 18, 2006 on June 20, 2007 at approximately 1:40 PM revealed that Thorazine dosage was increased on December 19, 2006 and that the day program stated that the client was sleeping for two hours after arriving at the day program and was not able to do programs. Review of a psychotropic review document dated December 19, 2006, on June 20, 2007 at approximately 1:45PM revealed that target behaviors are stable but need to be of lower frequency, Thorazine 300mg twice a day by mouth was increased to Thorazine 400mg twice a day by mouth. There was no documented evidence to substantiate that medication administered did not interfere with the clients' daily living activities. 5. Interview with LPN #2 and review of a nursing progress note dated May 15, 2007 on June 20, 2007 at approximately 1:50PM revealed that Client #1's father who is his legal medical surrogate decision maker had concerns regarding the client's side effects from the psychotropic medications administered to manage his targeted behaviors. Review of a psychotropic review dated May 15, 2007, on June 20, 2007 at approximately 1:55 PM revealed "some improvement ". Further review of the psychotropic review document revealed that in the side effects columns " none" was noted besides all of the psychotropic medications prescribed. There was no documented evidence	W 310	#4: Client #1 was actively being medically evaluated for the sedated behavior which began prior to the survey date by his primary physician after the neurologist introduced a new medication to Client #1's drug regime. The suspected offending drug was held pending further evaluation and follow up. #5: Client #1 was actively being medically evaluated for the sedated behavior which began prior to the survey date by his primary physician after the neurologist introduced a new medication to Client #1's drug regime. The suspected offending drug was held pending further evaluation and follow up.	

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W 310	Continued From page 14 to substantiate that medication administered did not interfere with the clients' daily living activities.	W 310		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on observation, interviews, and record reviewed, the facility failed to effectively train staff to implement emergency measures [Refer to W192]; the facility failed to ensure that medication administered for behavior management does not interfere with the daily living activities for Client #1 [Refer to W310]; failed to ensure health services were provided to meet the needs of the clients [Refer to W322]; the facility failed to establish systems to provide health care monitoring and identify services that would ensure nursing services were provided in accordance with clients needs [Refer to W331]; failed to provide evidence of training in emergency health care to staff [Refer to W342]. The results of these systemic practices results in the demonstrated failure of the facility to provide health care services.	W 318	W318 483.460 Health Care Services In response to W. 318, the facility says as follows: 1. The facility has now effectively trained the staff to implement emergency measures and the training was conducted on 7/10/07 2. The facility facilitated the interventions and reviews of the medications of client #1 by the PCP, Psychiatrist and the Neurologist resulting in medications adjustment and return of client #1 to Day Program. The facility will continue to aggressively monitor and report on the side effects and effectiveness of behavior management medications. 3. The facility had a meeting with PCP on 7/16/07and a review of the communication process between the PCP and the facility was made for more effectiveness. There is a more integrated communication line between the two parties, and this will ensure better health services to the individuals being served in the facility. 4. All efforts will be employed to obtain and attend to all follow up appointments or labs as required by the physician to meet the need of the clients and provide enhanced health services to the clients of the facility. 5. Any obstacles, delays or alteration to efforts to enhance the health care services to the individuals being served in the facility shall be clearly documented and reported. Efforts shall at all times be made to improve the monitoring and identification of services for the individuals being served in the facility	ongoing
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review failed to provide preventive and general care for three of three clients in the sample .	W 322		ongoing ongoing

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W 322	Continued From page 15 (Client #1, Client #2 and Client #3) The findings include: 1. The facility's medical services failed to respond to the facility's nursing staff when Client #1 was transported to the emergency room on June 20, 2007 for excessive sleepiness as evidenced by: Review of an unusual incident report dated June 20, 2007 at approximately 10:00AM revealed that Client #1 was observed sleeping on the couch when LPN #2 arrived on duty for medication pass at approximately 7:45AM. Client #1 appeared too drowsy at the time of medication pass and morning medications were not administered (Topamax 300mg by mouth for aggression, Revia 50 mg by mouth for self-injurious behavior, Thorazine 400mg by mouth for aggression and Clarinex 5mg by mouth for allergy control). Client #1 was transported to the emergency room for evaluation of excessive sleepiness at 9:05AM. Interview with LPN #2 and review of the Medication Administration Record (MAR) on June 20, 2007 at approximately 10:15AM revealed that Client #1 was administered Topamax 300mg, Revia 50 mg, Thorazine 400mg by mouth at 6:00PM and Klonopin 4mg by mouth at bedtime for sleep. Review of the Psychiatric Assessment dated November 4, 2006 on June 19, 2007 at approximately 12:32PM revealed that Client #1 has diagnosis of Autism and Psychotic Disorder NOS. Further interview with LPN #2 and review of the unusual incident report at approximately 10:25AM revealed that the PCP was paged two times at approximately 8:45AM and a message was left at his office with the receptionist at approximately 9:45AM to inform that Client #1	W 322	W322 483.460 (a) (3) Physician Services #1: The primary care physician for Client #1 did not respond in a timely manner to nursing phone calls. Nursing will exhaust all forms of communication with physicians: fax, paging, and direct conversation with physician's assistant (PA) in lieu of direct contact with primary and continued follow up phone calls as necessary with documentation of all efforts. Should the physician begin to demonstrate a pattern of unresponsiveness in the future, management will strive to resolve the underlying problem for appropriate resolution; failing those efforts to resolve the pattern of unresponsiveness, the corporation / facility will find it necessary to acquire health services from another physician.	

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W 322	Continued From page 16 was transported to the emergency room. There was no documented evidence during the time of the survey that the PCP responded to the facility's nursing staff when Client #1 was transported to the emergency room on June 20, 2007 for excessive sleepiness. [Note: Review of the emergency room report dated June 20, 2007 on June 20, 2007 at approximately 1:50PM revealed that no acute problems were diagnosed and that the client was advised to follow-up with the PCP for further evaluation and work-up for excessive sleeping.] 2. The facility's medical services failed to ensure that the referral for a MRI on June 14, 2007 was completed for Client #1 as evidenced by: Review of a Primary Care Physician (PCP) medical consult dated June 8, 2007 on June 20, 2007 at approximately 1:15PM revealed an order for a " MRI of the brain". Review of a radiology consult dated June 14, 2007 on June 20, 2007 at approximately 1:25PM revealed " MRI, did not have referral; PCP paged no call back; not able to keep still for exam ". There was no documented evidence that the referral for a MRI on June 14, 2007 was completed for Client #1 . 3. Cross refer to W310. The facility's medical services failed to ensure that medication administered for behavior management does not interfere with the daily living activities Client #1. 4. Cross refer to W331.1 The nursing staff failed to notify the PCP that Client #1's Depakote 500mg by mouth in the AM and Depakote 1000mg by mouth in the PM was being held because of excessive sleepiness.	W 322	#2: Referral for MRI was obtained and appointment completed for MRI on 06-20-2007. #3: Client #1 was actively being medically evaluated for the sedated behavior which began prior to the survey date by his primary physician after the neurologist introduced a new medication to Client #1's drug regime. The suspected offending drug was held pending further evaluation and follow up. #4: Nursing shall document all communications with physicians on the appropriate format. Any clarification of medical orders shall be consistently documented. Initial order from MD was to hold all medications for 4 days. The drug in suspect was not resumed with the medication regime with the knowledge of the MD.	

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W 322	Continued From page 17 5. Cross refer to W331.2. The facility's nursing services failed to ensure that Client #1 returned to the PCP's office in four days as recommended on June 8, 2007. 6. Cross refer to W331.3. The facility's nursing services failed to ensure that Client #1 returned to the neurologist as recommended on June 8, 2007. 7. Cross refer to W331.4. The facility's nursing services failed to ensure that the results of Client #1's Depakote, CBC and CMP laboratory studies were obtained. 8. Cross refer to W331.5 The facility's nursing services failed to ensure that Client #1's EEG was performed or scheduled as recommended. 9. Cross refer to W331.6 The facility's nursing services failed to ensure Client #3's laboratory studies were conducted timely as recommended. 10. Cross refer to W331.7. The facility's nursing services failed to obtain the results of Client # 3's urology consult. 11. Cross refer to W331.8. The facility's nursing services failed to weigh Client # 2 twice a mouth times one month as recommended by the PCP. 12. Cross refer to W342. The facility's nursing services failed to ensure that all staff working with the clients has been trained on the signs and symptoms of aspiration for Client #1,Client #2 and Client #3.	W 322	#5: Nursing shall document all communications with physicians on the appropriate format. Any clarification or modifications of medical orders shall be consistently documented. All efforts will be used to obtain and attend all follow up appointments as required by the physician. Any obstacles, delays or alteration to those efforts will be clearly documented.	ongoing
			#6: All efforts will be used to obtain and attend all follow up appointments or labs as required by the physician. Any obstacles, delays or alteration to those efforts will be clearly documented.	ongoing
			#7: Nursing has limited authority to obtain any lab reports since HIPPA. All results obtained and filed within the facility are as a result of cooperative work with the physician office who initiates obtaining the results from the processing lab.	
			#8: Client #1's EEG was scheduled twice by nursing. Client #1 arrived late to first appt due to am rush-hour traffic and the technician left as she had other schedules to keep. The appt. was re-booked by nursing at next available at any facility contacted, and it was kept by client #1 on 06-21-2007.	
			#9 - 11: All efforts will be used to obtain and attend all follow up appointments, labs or results as required by the physician. Any obstacles, delays or alteration to those efforts will be clearly documented.	ongoing
			#12 W322 Signs and symptoms of aspiration training were conducted on: June 27, 2007. This is an annual training.	
W 331	483.460(c) NURSING SERVICES	W 331		

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W 331	Continued From page 18 The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure nursing services in accordance with the needs of two of two clients in the sample. (Client #1 and Client # 3) The findings include: 1. The nursing staff failed to document notification to the Primary Care Physician (PCP) that Client #1's Depakote 1000 mg was being not being administered as recommended because of excessive sleepiness as evidenced by: During evening medication observation on June 18, 2007 at approximately 4:45 PM the Licensed Practical Nurse #1 (LPN) revealed that Client #1's Depakote 1000 mg by mouth was not being administered per the Primary Care Physician's (PCP) orders. Interview with LPN #1 on June 20, 2007 at approximately 5:55 PM revealed that the nursing staff was not administering the Depakote because Client #1 was experiencing excessive sleepiness. Further interview revealed that the client's father revealed that the client had a history of seizures but had not had a seizure in thirteen years. Review of the Medication Administration Record (MAR) on June 18, 2007 at approximately 5:10PM confirmed that Depokate was not being administered. Review of a telephone order dated May 31, 2007 on June 20, 2007 at approximately 1:00 PM revealed that Client #1 was ordered Depakote 500 mg by mouth every eight hours for seizure disorder by the neurologist. Review of a telephone order	W 331	W331 483.460 (c) Nursing Services #1: Nursing shall document all communications with physicians on the appropriate format. Any clarification of medical orders shall be consistently documented. Initial order from MD was to hold all medications for 4 days. The drug in suspect was not resumed with the medication regime with the knowledge of the MD.	ongoing

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W 331	Continued From page 19 dated June 1, 2007 on June 20, 2007 at approximately 1:05PM revealed that the Depakote order was changed to Depakote 500 mg by mouth every AM and Depakote 1000 mg by mouth every PM. Review of a telephone order dated June 6, 2007 on June 20, 2007 at approximately 1:10 PM revealed an order to " hold Clonazepam this evening; hold Depakote for forty- eight hours...". Review of a PCP medical consult dated June 8, 2007 on June 20, 2007 at approximately 1:15PM revealed an order to " hold all prescription medication for the next four days; call me if there is a problem.....". There was no documented evidence that the PCP was made aware that the Depakote was not being administered after four days as recommended due to excessive sleepiness. 2. The facility's nursing services failed to ensure that Client #1 returned to the PCP's office in four days as recommended on June 8, 2007 as evidenced by: Review of a PCP medical consult dated June 8, 2007 on June 20, 2007 at approximately 1:15 PM revealed an order to " hold all prescription medication for the next four days; call me if there is a problem; return in four days." In an interview with LPN #2 it was acknowledged that Client #1 did not return to the PCP's office in four days as recommended. There was no documented evidence that Client #1 returned to the PCP's office in four days as recommended on June 8, 2007. 3. The facility's nursing services failed to ensure that Client #1 returned to the neurologist as recommended on June 6, 2007 as evidenced by:	W 331	#2: All efforts will be used to obtain and attend all follow up appointments or labs as required by the physician. Any obstacles, delays or alteration to those efforts will be clearly documented.	ongoing

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W 331	Continued From page 20 Review of a telephone order dated June 6, 2007 on June 20, 2007 at approximately 1:10 PM revealed an order to " hold Depakote for forty-eight hours...have patient see neurologist for re-evaluation of medication." In an interview with LPN #2 on June 20, 2007 at approximately 1:16 PM it was acknowledged that Client #1 did not return to the neurologist for re-evaluation as recommended. There was no documented evidence that Client #1 returned to the neurologist for re-evaluation as recommended on June 6, 2007. 4. The facility's nursing services failed to ensure that the results of Client #1's Depakote , CBC and CMP laboratory studies were obtained as evidenced by: Review of a PCP medical consult dated June 8, 2007 on June 20, 2007 at approximately 1:15PM revealed an order for "Depakote levels,CBC and CMP today." Interview with LPN #2 on June 20, 2007 at approximately 1:20 PM revealed Client #1's Depakote, CBC and CMP levels were drawn on June 8, 2007 in the PCP's office. There was no documented evidence that the results of the Depakote, CBC and CMP levels were obtained by the facility. [Note: Telephone interview with LPN #2 on June 21, 2007 at approximately 12:30PM revealed that the results of Client #1's Depakote, CBC and CMP levels will be faxed to the facility on June 21, 2007] 5. The facility's nursing services failed to ensure that Client #1's EEG was performed or scheduled as evidenced by:	W 331	#3: All efforts will be used to obtain and attend all follow up appointments or labs as required by the physician. Any obstacles, delays or alteration to those efforts will be clearly documented. #4: Nursing has limited authority to obtain any lab reports since HIPPA. All results obtained and filed within the facility are as a result of cooperative work with the physician office who initiates obtaining the results from the processing lab. The physician had possession of the results and the report is filed within the medical record in the facility. #5: Client #1's EEG was scheduled twice by nursing. Client #1 arrived late to first appt due to am rush-hour traffic and the technician left as she had other schedules to keep. The appt. was re-booked by nursing at next available at any facility contacted, and it was kept by client #1 on 06-21-2007.	ongoing

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W 331	Continued From page 21 Review of the Primary Care Physician's orders dated June 8, 2007 on June 20, 2007 at approximately 11:50AM revealed a recommendation for Client #1 to have an EEG. Interview with LPN #2 on June 20, 2007 at approximately 10:55AM revealed that the laboratory study had not been performed or scheduled. There was no evidence that the EEG was performed or scheduled as recommended. [Note: Telephone interview with LPN #2 on June 21, 2007 at approximately 12:25PM revealed that Client #1 is scheduled for an EEG on June 26, 2007] 6. The facility's nursing services failed to ensure Client #3's laboratory studies were conducted timely as evidenced by: Review of the Primary Care Physician's orders dated May, 2007 on June 18, 2007 at approximately 3:50PM revealed a recommendation for Client #3 to have primidone plasma levels done every three months. Interview with Qualified Mental Retardation Professional (QMRP) on June 19, 2007 at approximately 3:51PM revealed that the laboratory study had not been performed or scheduled. Review of the medical record on June 19, 2007 at approximately 3:52 PM revealed no documented evidence of the laboratory studies for primidone plasma levels since October, 2006. There was no evidence that the laboratory study was obtained as recommended. 7. The facility's nursing services failed to obtain the results of Client # 3's urology consult as evidenced by:	W 331	#6: All efforts will be used to obtain and attend all follow up appointments or labs as required by the physician. Any obstacles, delays or alteration to those efforts will be clearly documented.	ongoing

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W 331	Continued From page 22 Review of a urology consult dated June 6, 2006 on June 19, 2007 at approximately 3:40 PM revealed that Client #3 had an examination performed on June 6, 2007. In an interview with the QMRP on June 19, 2007 at approximately 2:45 PM it was acknowledged that Client #3's urology results had not been obtained by the facility. There was no documented evidence that Client #3's urology results had not been obtained by the facility. 8. The facility's nursing services failed to weigh Client # 2 as evidenced by: Review of the Primary Care Physician's (PCP's) progress note revealed a recommendation for Client #2 to be weighed twice a week for one month. In an interview with the LPN on June 20, 2007 at approximately 12:15PM it was acknowledged that Client #2 was not weighed twice a week for one month as recommended. There was no documented evidence that Client #2 was weighed twice a week for one month by the facility. 9. Cross refer to W342. The facility's nursing services failed to ensure that all staff working with the clients has been trained on the signs and symptoms of aspiration for Client #1,Client #2 and Client #3.	W 331	#7: All efforts will be used to obtain and attend all follow up appointments or labs as required by the physician. Any obstacles, delays or alteration to those efforts will be clearly documented. #8: Nursing shall ensure that all medical orders are carried out and any modification in any order or, inability to completely carry out any order is clearly communicated and documented. #9: Signs and symptoms of aspiration training was conducted on: June 27, 2007.	ongoing ongoing
W 342	483.460(c)(5)(iii) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to	W 342		

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W 342	Continued From page 23 meet the health needs of the clients. This STANDARD is not met as evidenced by: Based on interview with staff and review of the records, the facility's nursing services failed to ensure that all staff working with the clients has been trained on the signs and symptoms of aspiration for three of three clients in the sample. (Client #1,Client #2 and Client #3) The findings include: 1. Observation of the dinner meal on June 18, 2007 at approximately 6:05PM revealed that the client's one to one had to give him verbal prompts to slow down his eating pace. Further observation revealed that the client did comply and slowed down his eating pace. Review of staff training records on June 19, 2007 at approximately 1:15PM revealed no evidence that staff received training to address the signs and symptoms of aspiration. Review of Client #1's Speech Therapist assessment dated November 11, 2006 on June 19, 2006 at approximately 1:10PM revealed a recommendation to monitor client for rapid eating at mealtime. There was no evidence of training on the signs and symptoms of aspiration. 2. Observation of the dinner meal on June 18, 2007 at approximately 6:15PM revealed that the client's one to one had to give him verbal prompts to slow down his eating pace. Further observation revealed that the client did comply and slowed down his eating pace. Review of staff training records on June 19, 2007 at approximately 1:15PM revealed no evidence that staff received training to address the signs and	W 342	W342 **#1 - 3: Signs and symptoms of aspiration training was conducted on: 06-27-2007. Prior training was conducted by SLP a year ago.**	

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W 342	Continued From page 24 symptoms of aspiration. Review of Client #2's Speech Therapist assessment dated October 14, 2006 on June 19, 2006 at approximately 10:54AM revealed a recommendation to monitor client for rapid eating at mealtime. There was no evidence of training on the signs and symptoms of aspiration. 3. Observation of the dinner meal on June 18, 2007 at approximately 6:15PM revealed that the client had to given verbal prompts to slow down his eating pace. Further observation revealed that the client did comply and slowed down his eating pace. Review of staff training records on June 19, 2007 at approximately 1:15PM revealed no evidence that staff received training to address signs and symptoms of aspiration. Review of Client #3's Speech Therapist assessment dated May 28, 2006 on June 19, 2006 at approximately 9:50AM revealed a recommendation to monitor the client for rapid eating. There was no evidence of training on the signs and symptoms of aspiration.	W 342	W342 #1 - 3: Signs and symptoms of aspiration training was conducted on: 06-27-2007. Prior training was conducted by SLP a year ago. This is an annual training for all staff.	
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that clients owned and/or consistently utilized prescribed adaptive equipment, for two of three clients in the	W 436		

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W 436	Continued From page 25 sample. (Client #1 and Client #3) The findings include: 1. Dinner observation on June 18, 2007 at approximately 6:05 PM revealed that Client #1 was using a bulit-up handled teaspoon in his right hand to eat his prescribed diet from a scoop plate. In an interview with the client's one to one on June 18, 2007 at approximately 6:15 PM it was acknowledged that Client #1 used a scoop plate instead of a plate guard during mealtime. Review of the OT assessment dated November 11, 2006 on June 19, 2007 at approximately 12:55 PM revealed a recommendation for Client #1 to utilize a plate guard. Review of the Individual Support Plan (ISP) dated November 14, 2006 on June 8, 2007 at approximately 12:45 PM revealed that it was recommended that Client #1 utilize a plate guard during mealtime. There was no evidence that Client #1 used a plate guard at mealtime as recommended by the ISP. 2. Observation during the lunch mealtime on June 18, 2007 at approximately 11:40 AM revealed that Client #3 was served his prescribed diet in a divided plate and he was holding a built-up angled spoon in his right hand. Further observation revealed that Client #3 coughed twice when drinking from the paper cup. In an interview with the day program staff on June 18, 2007 at approximately 11:50 PM it was acknowledged that Client #3 used a paper cup instead of an opened handled spout mug during mealtime. Further interview revealed that Client #3 did have an opened handled spout mug to use at the day program during mealtime. Review of the Individual Support Plan (ISP) dated June 13, 2006 on June 19, 2007 at approximately 9:25 AM	W 436	In response to W 436, the facility says as follows: As answer to W 436(1), the facility says that: 1. Although the purpose of the use of a plate guard is to prevent spillage and a scoop plate also prevents spillage, the direct care staff has been retrained to ensure that client #1 uses only plate guard during mealtime until the OT reviews the assessment. The QMRP and the Manager will aggressively monitor the staff to ensure consistent compliance with this protocol. 2. As response to W 436(2), the facility say as follows: a. The Day Program was fully aware that client #3 uses an open handled spout mug. b. Client continues to use an open handled spout mug in the day program. The QMRP will further have	6/27/07 and ongoing ongoing 7/26/07

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W 436	Continued From page 26 revealed that it was recommended that Client #3 utilize an opened handled spout mug during mealtime. Review of the Speech Therapist assessment dated May 28, 2006 on June 19, 2007 at approximately 9:50AM revealed a recommendation to monitor client for rapid eating. There was no evidence that Client #3 used an opened handled spout mug at mealtime as recommended by the ISP at the day program. 3. Observation during the dinner mealtime in the facility on June 18, 2007 at approximately 6:05 PM revealed that Client #3 was served his prescribed diet in a divided plate and he was holding a built-up angled spoon in his right hand. Further observation revealed that Client #3 coughed twice when drinking from a standard type cup. In an interview with the direct care staff on June 18, 2007 at approximately 6:12 PM it was acknowledged that Client #3 used a standard cup instead of an opened handled spout mug during mealtime. Review of the Individual Support Plan (ISP) dated June 13, 2006 on June 19, 2007 at approximately 9:25 AM revealed that it was recommended that Client #3 utilize an opened handled spout mug during mealtime. Review of the Speech Therapist assessment dated May 28, 2006 on June 19, 2006 at approximately 9:50AM revealed a recommendation to monitor client for rapid eating. There was no evidence that Client #3 used an opened handled spout mug at mealtime as recommended by the ISP. 4. During an environmental observation of all client areas on June 19, 2007 at approximately 10:00AM revealed that there was not a shower chair in the facility for Client #3 to utilize during bathtime. In an interview with the QMRP on June 19, 2007 at approximately 10:15 AM it was	W 436	3. As a response to W. 436(3) the facility says the direct care staff has been in serviced to ensure that client # 3 and other individuals being served use the appropriate and recommended adaptive equipments during mealtime. The QMRP and the House Manager will monitor the staff to ensure full compliance with the mealtime protocol for all the individuals being served in the facility. #4: ~~Client #3 has the use of a built-in shower~~ bench, making an additional shower chair redundant, and reducing bathing space. Prior to the home's relocation to this facility, a shower chair was utilized, and then discarded after our move. The purpose of using a "shower chair" is for the person to sit safely while bathing; the shower bench facilitates this purpose.	6/27/07 and ongoing 6/27/07 and ongoing

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W 436	Continued From page 27 acknowledged that Client #3 did not have a shower chair. Review of Client #3's OT assessment dated May 20, 2006, at approximately 10:30AM on June 19, 2007 revealed a recommendation that the client have a shower chair. There was no evidence that the Client #3 had a a shower chair as recommended by the OT.	W 436		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to hold evacuation drills quarterly on all shifts. The finding includes: Review of the available fire drill records dated from January 18, 2007, to June 4, 2007 on June 19, 2007 at approximately 9:00 AM revealed that fire drills were not conducted on the evening and night shift during the second quarter. Further review revealed that fire drills were not conducted on the day and evening shifts during the third quarter. There was no evidence that every shift of personnel conducted an evacuation drill at least quarterly.	W 440	W440 483.470 (i)(1) Evacuation Drills As per corporate & facility policy, emergency evacuation drills are to be conducted quarterly on each shift. The facility conducts monthly evacuation drills alternating through the shifts. This First Street facility admitted residents on 01-26-2007. Prior to move-in day, staff & residents participated in their first fire drill on 01-19-2007 at 11 am. A fire drill was conducted on different shifts in subsequent months. All fire drills will be conducted as provided for in the policy with usage of different means of egress. No alteration to the pattern will be made by staff.	
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on staff interview and record verification,	W 441		

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W 441	Continued From page 28 the facility failed to hold evacuation drills under varied conditions. The finding includes: On June 18, 2007 at approximately 9:25AM review of fire drill records and interview with the Qualified Mental Retardation Professional (QMRP) revealed that during the past year, staff had not practiced exiting through all five egresess of the facility. Most fire drills were conducted via the front and side exits. There was no evidence that evacuation drills were being held under varied conditions.	W 441	**W441 483.470 (i) (1) Evacuation Drills** **As per corporate & facility policy, emergency evacuation drills are to be conducted quarterly on each shift. The facility conducts monthly evacuation drills alternating through the shifts. This First Street facility admitted residents on 01-26-2007. Prior to move-in day, staff & residents participated in their first fire drill on 01-19-2007 at 11 am. A fire drill was conducted on different shifts in subsequent months. All fire drills will be conducted as provided for in the policy with usage of different means of egress. No alteration to the pattern will be made by staff.**	

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I 000	INITIAL COMMENTS A recertification survey was conducted from June 18, 2007 thru June 20, 2007. The survey was initiated using the fundamental survey process. A random sample of three residents was selected from a resident population of six males with various disabilities. The survey findings were based on observations in the group home, interviews with residential, nursing and administrative staff. Review of records, including investigations of unusual incidents was also conducted. The survey findings determined that the facility failed to substantially comply with the Condition of Participation in Governing Body and Health Care Services.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observations, interviews and review of records, the facility's governing body provided general operating direction over the facility, except in the following areas: The finding includes: The governing body failed to ensure the maintenance of the facility's environment, as evidenced by: a. Loose frame on wooden chair b. Carpet has loose strips in television area	I 090	3504.1 HOUSE KEEPING In response to 1090, the facility says as follows: a. Loose frame on wooden chair has been fixed b. Loose carpet strips in television area has been fixed and will further be maintained until replaced completely c. Loose carpet strips at the doorway of client #3's bedroom has been fixed and will be further be maintained until replaced completely.	6/21/07 and ongoing

Ilene D. Wilson

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE President/CEO

(X6) DATE 07-24-07

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I 090	Continued From page 1 c. Carpet has loose strips at the doorway of Resident #3's bedroom d. Torn areas on the armrests of four upholstered chairs along the wall between teevision area and living room e. Chipped tile on raised area of large hallway shower room f. Lamp shade torn/bent in Resident #3's room	I 090		
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to hold evacuation drills quarterly on all shifts. The finding includes: Review of the available fire drill records dated from January 18, 2007, to June 4, 2007 on June 19, 2007 at approximately 9:00 AM revealed that fire drills were not conducted on the evening and night shift during the second quarter. Further review revealed that fire drills were not conducted on the day and evening shifts during the third quarter. There was no evidence that every shift of personnel conducted an evacuation drill at least quarterly.	I 135	I 135 3505.5 FIRE SAFETY As per corporate & facility policy, emergency evacuation drills are to be conducted quarterly on each shift. The facility conducts monthly evacuation drills alternating through the shifts. This First Street facility admitted residents on 01-26-2007. Prior to move-in day, staff & residents participated in their first fire drill on 01-19-2007 at 11 am. A fire drill was conducted on different shifts in subsequent months. All fire drills will be conducted as provided for in the policy with usage of different means of egress. No alteration to the pattern will be made by staff.	07-20-2007

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I 227	Continued From page 2	I 227	I 227 3510.5 (d) STAFF TRAINING	
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to effectively train staff to implement emergency measures for six of six clients in the facility. (Clients #1, #2, #3, #4, 5 and 6) The findings include: 1. Interview with the QMRP on June 19, 2007 at approximately 1:45 PM revealed that all staff would be trained in CPR by June 22, 2007. Record review on June 19, 2007 at approximately 1:50 PM revealed that nine out of twenty staff did not have current CPR certification. There was no documented evidence that all direct care staff had CPR training and current CPR certifications. 2. Interview with the QMRP on June 19, 2007 at approximately 1:55 PM revealed that all staff would be trained in First Aid by June 22, 2007. Record review on June 19, 2007 at approximately 2:00 PM revealed that seven out of twenty staff did not have current First Aid certification. There was no documented evidence that all direct care staff had First Aid training and current First Aid certifications.	I 227	#1 & #2: Staff training had indeed expired and re-training in CPR and First Aid had been scheduled with an outside qualified trainer on the best available date. However, each shift did have coverage by a staff person whose certification had not expired. Staff have attended/ passed CPR and First Aid training.	07-10-2007
I 391	3520.2(a) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor	I 391		

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I 391	Continued From page 3 necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (a) Medicine; This Statute is not met as evidenced by: Based on observation, staff interview, and record review failed to provide preventive and general care for three of three clients in the sample . (Resident #1, Resident #2 and Resident #3) The findings include: 1. The facility's medical services failed to respond to the facility's nursing staff when Resident #1 was transported to the emergency room on June 20, 2007 for excessive sleepiness as evidenced by: Review of an unusual incident report dated June 20, 2007 at approximately 10:00AM revealed that Resident #1 was observed sleeping on the couch when LPN #2 arrived on duty for medication pass at approximately 7:45AM. Resident #1 appeared too drowsy at the time of medication pass and morning medications were not administered (Topamax 300mg by mouth for aggression, Revia 50 mg by mouth for self-injurious behavior, Thorazine 400mg by mouth for aggression and Clarinex 5mg by mouth for allergy control). Resident #1 was transported to the emergency room for evaluation of excessive sleepiness at	I 391	I 391 3520.2 (a) Profession Services: General Provisions #1: The primary care physician for Resident #1 did not respond in a timely manner to nursing phone calls. Nursing will exhaust all forms of communication with physicians: fax, paging, and direct conversation with physician's assistant (PA) in lieu of direct contact with primary and continued follow up phone calls as necessary with documentation of all efforts. Should the physician begin to demonstrate a pattern of unresponsiveness in the future, management will strive to resolve the underlying problem for appropriate resolution; failing those efforts to resolve the pattern of unresponsiveness, the corporation / facility will find it necessary to acquire health services from another physician.	07-21-2007

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I 391	Continued From page 4 9:05AM. Interview with LPN #2 and review of the Medication Administration Record (MAR) on June 20, 2007 at approximately 10:15AM revealed that Resident #1 was administered Topamax 300mg, Revia 50 mg, Thorazine 400mg by mouth at 6:00PM and Clonazepam 2mg by mouth at bedtime for sleep. Review of the Psycological Assessment dated November 11, 2006 on June 19, 2007 at approximately 12:50PM revealed that Resident #1 has diagnosis of Autism and Psychotic Disorder NOS. Further interview with LPN #2 and review of the unusual incident report at approximately 10:25AM revealed that the PCP was paged two times at approximately 8:45AM and a message was left at his office with the receptionist at approximately 9:45AM to inform that Resident #1 was transported to the emerency room. There was no documented evidence during the time of the survey that the PCP responded to the facility's nursing staff when Resident #1 was transported to the emergency room on June 20, 2007 for excessive sleepiness. [Note: Review of the emerency room report dated June 20, 2007 on June 20, 2007 at approximately 1:50PM revealed that no acute problems were diagnosed and that Resident #1 was advised to follow-up with the PCP for further evaluation and work-up for excessive sleeping.] 2. The facility's medical services failed to ensure that the referral for a MRI on June 14, 2007 was completed for Resident #1 as evidenced by: Review of a Primary Care Physician (PCP) medical consult dated June 8, 2007 on June 20, 2007 at approximately 1:15PM revealed an order for a " MRI of the brain". Review of a radiology consult dated June 14, 2007 on June 20, 2007 at approximately 1:25PM revealed " MRI, did not	I 391	#2: Referral for MRI was obtained and appointment completed for MRI on 06-20-2007.	06-21-2007

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I 391	Continued From page 5 have referral; PCP paged no call back; not able to keep still for exam ". There was no documented evidence that the referral for a MRI on June 14, 2007 was completed for Resident #1 3. The facility's medical services failed to ensure that medication administered for behavior management does not interfere with the daily living activities for Resident #1 as evidenced by: a. Observation of Resident #1 on June 19, 2007 approximately between 12:45PM- 2:30PM revealed that Resident #1 appeared to be drifting in and out of sleep during that period of time as he laid on the couch in the living room. Further observation revealed that with several physical/verbal prompts the client was able to get up and go to the bathroom with his one to one staff member. Interview with the Administrator on June 19, 2007 at approximately 2:15PM revealed that they did not want to awaken the client because the facility wanted the psychiatrist to observe how Resident #1 was excessively sleeping when he came to the psychotropic review meeting that was scheduled that day. There was no documented evidence to substantiate that medication administered did not interfere with the resident's daily living activities. [Note: ~~The psychiatrist~~ did not come to the facility for the planned psychotropic review meeting on June 19, 2007] b. Cross refer to W332.1 and W331.1. Review of an unusual incident report dated June 20, 2007 at approximately 10:00AM revealed that Resident #1 was observed sleeping on the couch when LPN #2 arrived on duty for medication pass at approximately 7:45AM. Resident #1 appeared too	I 391	I 391 3520.2 (a) Profession Services: General Provisions #3 (a – c): Resident #1 was actively being medically evaluated for the sedated behavior which began prior to the survey date by his primary physician after the neurologist introduced a new medication to Client #1's drug regime. The suspected offending drug was held pending further evaluation and follow up. The psychiatrist did visit the facility on 06-21-2007. The primary care physician reviewed all results from EEG, MRI and labs; resident was cleared to attend day program activities on 07-16-2007. Further adjustment in medication prescribed has rebalanced his alertness. The psychotropic medication review team shall continue to monitor and evaluate the effectiveness of drug regime; clearly and fully documenting all concerns, observed and reported side effects.	07-20-2007 On-going

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I 391	Continued From page 6 drowsy at the time of medication pass and morning medications were not administered (Topamax 300mg, Revia 50 mg, Thorazine 400mg and Clarinex 5mg by mouth). Client #1 was transported to the emergency room for evaluation of excessive sleepiness at 9:05AM. Interview with LPN #2 and review of the Medication Administration Record (MAR) on June 20, 2007 at approximately 10:15AM revealed that Resident #1 was administered Topamax 300mg, Revia 50 mg, Thorazine 400mg by mouth at 6:00PM and Klonopin 4 mg by mouth at bedtime on June 19, 2007. There was no documented evidence to substantiate that medication administered did not interfere with the resident's daily living activities. c. Interview with the Director of the day program on June 21, 2007 at approximately 11:45 AM, revealed that on November 1, 2006 and on November 20, 2006 the facility was informed that Resident #1 was observed to sleep from the time he arrived at the day program until around lunch time (11:00 AM-11:30 AM) and sometimes would fall asleep while eating his lunch. Further interview revealed that Resident #1 last attended day program on June 7, 2007 and will need to be medically cleared before returning to the day program. Review of a psychotropic review document dated November 20, 2006 on June 20, 2007 at approximately 1:35PM revealed that "some sedation reported by day program". Further review psychotropic review document revealed that Topamax 400mg twice a day by mouth was decreased to Topamax 300mg twice a day by mouth. [Note: The Primary Care Physician (PCP) has not medically cleared Resident #1 to attend the day program]	I 391	I 391 3520.2 (a) Profession Services: General Provisions #3 (a - c): Resident #1 was actively being medically evaluated for the sedated behavior which began prior to the survey date by his primary physician after the neurologist introduced a new medication to Client #1's drug regime. The suspected offending drug was held pending further evaluation and follow up. The psychiatrist did visit the facility on 06-21-2007. The primary care physician reviewed all results from EEG, MRI and labs; resident was cleared to attend day program activities on 07-16-2007. Further adjustment in medication prescribed has rebalanced his alertness. The psychotropic medication review team shall continue to monitor and evaluate the effectiveness of drug regime; clearly and fully documenting all concerns, observed and reported side effects.	07-20-2007 On-going

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I 391	Continued From page 7 d. Interview with LPN #2 and review of an AIMS assessment dated December 18, 2006 on June 20, 2007 at approximately 1:40 PM revealed that Thorazine dosage was increased on December 19, 2006 and that the day program stated that the Resident #1 was sleeping for two hours after arriving at the day program and was not able to do programs. Review of a psychotropic review document dated December 19, 2006, on June 20, 2007 at approximately 1:45PM revealed that target behaviors are stable but need to be of lower frequency, Thorazine 300mg twice a day by mouth was increased to Thorazine 400mg twice a day by mouth. There was no documented evidence to substantiate that medication administered did not interfere with the resident's daily living activities. e. Interview with LPN #2 and review of a nursing progress note dated May 15, 2007 on June 20, 2007 at approximately 1:50PM revealed that Resident #1's father who is his legal medical surrogate decision maker had concerns regarding the residents's side effects from the psychotropic medications administered to manage his targeted behaviors. Review of a psychotropic review dated May 15, 2007, on June 20, 2007 at approximately 1:55 PM revealed "some ~~impro~~vement ". Further review of the psychotropic review document revealed that in the side effects columns "none" was noted besides all of the psychotropic medications prescribed. There was no documented evidence to substantiate that medication administered did not interfere with the resident's daily living activities.	I 391	I 391 3520.2 (a) Profession Services: General Provisions #3 (d - e): As per policy, monitoring of the side effects of psychotropic medications shall be on-going occurring every six months, utilizing the MOSES form. The MOSES shall be reviewed by the prescribing psychiatrist. The psychotropic medication review team will completely document all observed and reported side effects of medications, and, the team's recommended actions on the meeting review sheet.	On-going

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I 395	Continued From page 8	I 395		
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (e) Nursing; This Statute is not met as evidenced by: Based on staff interview and record review the facility failed to ensure nursing services in accordance with the needs of two of two residents in the sample. (Resident #1 and Resident # 3) The findings include: 1. The nursing staff failed to document notification to the Primary Care Physician (PCP) that Resident #1's Depakote 1000 mg was being not being administered as recommended because of excessive sleepiness as evidenced by: During evening medication observation on June 18, 2007 at approximately 4:45 PM the Licensed Practical Nurse #1 (LPN) revealed that Resident #1's Depakote 1000 mg by mouth was not being administered per the Primary Care Physician's (PCP) orders. Interview with LPN #1 on June 20, 2007 at approximately 5:55 PM revealed that the	I 395		

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I 395	Continued From page 9 nursing staff was not administering the Depakote because the Resident #1 was experiencing excessive sleepiness. Further interview revealed that the client's father revealed that Resident #1 had a history of seizures but had not had a seizure in thirteen years. Review of the Medication Administration Record (MAR) on June 18, 2007 at approximately 5:10PM confirmed that Depokate was not being administered. Review of a telephone order dated May 31, 2007 on June 20, 2007 at approximately 1:00 PM revealed that the Resident #1 was ordered Depakote 500 mg by mouth every eight hours for seizure disorder by the neurologist. Review of a telephone order dated June 1, 2007 on June 20, 2007 at approximately 1:05PM revealed that the Depakote order was changed to Depakote 500 mg by mouth every AM and Depakote 1000 mg by mouth every PM. Review of a telephone order dated June 6, 2007 on June 20, 2007 at approximately 1:10 PM revealed an order to " hold Clonazepam this evening; hold Depakote for forty- eight hours...". Review of a PCP medical consult dated June 8, 2007 on June 20, 2007 at approximately 1:15PM revealed an order to "hold all prescription medication for the next four days; call me if there is a problem.....". There was no documented evidence that the PCP was made aware that the Depakote was not being administered after four days as recommended due to excessive sleepiness. 2. The facility's nursing services failed to ensure that Resident #1 returned to the PCP's office in four days as recommended on June 8, 2007 as evidenced by: Review of a PCP medical consult dated June 8, 2007 on June 20, 2007 at approximately 1:15 PM revealed an order to " hold all prescription	I 395	I 395 3520.2 (e) Profession Services: General Provisions (e) Nursing #1: Nursing shall document all communications with physicians on the appropriate format. Any clarification of medical orders shall be consistently documented. Initial order from MD was to hold all medications for 4 days. The drug in suspect was not resumed with the medication regime with the knowledge of the MD. #2: All efforts will be used to obtain and attend all follow up appointments or labs as required by the physician. Any obstacles, delays or alteration to those efforts will be clearly documented.	06-21-2007 On-going On-going

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I 395	Continued From page 10 medication for the next four days; call me if there is a problem; return in four days." In an interview with LPN #2 it was acknowledged that Resident #1 did not return to the PCP's office in four days as recommended. There was no documented evidence that Resident #1 returned to the PCP's office in four days as recommended on June 8, 2007. 3. The facility's nursing services failed to ensure that Resident #1 returned to the neurologist as recommended on June 6, 2007 as evidenced by: Review of a telephone order dated June 6, 2007 on June 20, 2007 at approximately 1:10 PM revealed an order to "hold Depakote for forty-eight hours...have patient see neurologist for re-evaluation of medication." In an interview with LPN #2 on June 20, 2007 at approximately 1:16 PM it was acknowledged that Resident #1 did not return to the neurologist for re-evaluation as recommended. There was no documented evidence that Resident #1 returned to the neurologist for re-evaluation as recommended on June 6, 2007. 4. The facility's nursing services failed to ensure that the results of Resident #1's Depakote , CBC and CMP laboratory studies were obtained as evidenced by: Review of a PCP medical consult dated June 8, 2007 on June 20, 2007 at approximately 1:15PM revealed an order for "Depakote levels,CBC and CMP today." Interview with LPN #2 on June 20, 2007 at approximately 1:20 PM revealed Resident #1's Depakote, CBC and CMP levels were drawn on June 8, 2007 in the PCP's office. There was no documented evidence that the results of the Depakote, CBC and CMP levels	I 395	I 395 3520.2 (e) Profession Services: General Provisions (e) Nursing #3: All efforts will be used to obtain and attend all follow up appointments or labs as required by the physician. Any obstacles, delays or alteration to those efforts will be clearly documented. Resident #1 did return to the neurologist after all tests were completed & results in-hand at the earliest available appointment on 07-19-07. #4: Nursing has limited authority to obtain any lab reports since HIPPA. All results obtained and filed within the facility are as a result of cooperative work with the physician office who initiates obtaining the results from the processing lab. The primary care physician had possession and knowledge of the lab results; on 06-21-07, copies of the results were made available for filing in the facility record.	07-20-2007 On-going On-going

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I 395	Continued From page 11 were obtained by the facility. [Note: Telephone interview with LPN #2 on June 21, 2007 at approximately 12:30PM revealed that the results of Resident #1's Depakote, CBC and CMP levels will be faxed to the facility on June 21, 2007] 5. The facility's nursing services failed to ensure that Resident #1's EEG was performed or scheduled as evidenced by: Review of the Primary Care Physician's orders dated June 8, 2007 on June 20, 2007 at approximately 11:50AM revealed a recommendation for Resident #1 to have an EEG. Interview with LPN #2 on June 20, 2007 at approximately 10:55AM revealed that the laboratory study had not been performed or scheduled. There was no evidence that the EEG was performed or scheduled as recommended. [Note: Telephone interview with LPN #2 on June 21, 2007 at approximately 12:25PM revealed that Resident #1 is scheduled for an EEG on June 26, 2007] 6. The facility's nursing services failed to ensure Resident #3's laboratory studies were conducted timely as evidenced by: Review of the Primary Care Physician's orders dated May, 2007 on June 18, 2007 at approximately 3:50PM revealed recommendation for Resident #3 to have primidone plasma levels done every three months. Interview with Qualified Mental Retardation Professional (QMRP) on June 19, 2007 at approximately 3:51PM revealed that the laboratory study had not been performed or scheduled. Review of the medical record on	I 395	I 395 (e) Nursing #5: Client #1's EEG was scheduled twice by nursing. Client #1 arrived late to first appt due to am rush-hour traffic and the technician left as she had other schedules to keep. The appt. was re-booked by nursing at next available at any facility contacted, and it was kept by client #1 on 06-21-2007. #6: All efforts will be used to obtain and attend all follow up appointments, labs or results as required by the physician. Any obstacles, delays or alteration to those efforts will be clearly documented.	06-21-2007 06-21-2007 On-going

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I 395	Continued From page 12 June 19, 2007 at approximately 3:52 PM revealed no documented evidence of the laboratory studies for primidone plasma levels since October, 2006. There was no evidence that the laboratory study was obtained as recommended. 7. The facility's nursing services failed to obtain the results of Resident # 3's urology consult as evidenced by: Review of a urology consult dated June 6, 2006 on June 19, 2007 at approximately 3:40 PM revealed that Resident #3 had an examination performed on June 6, 2007. In an interview with the QMRP on June 19, 2007 at approximately 2:45 PM it was acknowledged that Resident #3's urology results had not been obtained by the facility. There was no documented evidence that Resident #3's urology results had not been obtained by the facility. 8. The facility's nursing services failed to weigh Resident # 2 as evidenced by: Review of the Primary Care Physician's (PCP's) progress note revealed a recommendation for Resident #2 to be weighed twice a week for one month. In an interview with the LPN on June 20, 2007 at approximately 12:15PM it was acknowledged that Resident #2 was not weighed twice a week for one month as recommended. There was no documented evidence that Resident #2 weighed twice a week for one month by the facility. 9. The facility's nursing services failed to ensure that all staff working with the clients has been trained on the signs and symptoms of aspiration for Resident #1, Resident #2 and Resident #3	I 395	I 395 (e) Nursing **#7 - 8: All efforts will be used to obtain and attend all follow up appointments, labs or results as required by the physician. Any obstacles, delays or alteration to those efforts will be clearly documented.**	07-20-2007

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I 395	Continued From page 13 as evidenced: a. Observation of the dinner meal on June 18, 2007 at approximately 6:05PM revealed that the resident's one to one had to give him verbal prompts to slow down his eating pace. Further observation revealed that the resident did comply and slowed down his eating pace. Review of staff training records on June 19, 2007 at approximately 1:15PM revealed no evidence that staff received training to address the signs and symptoms of aspiration. Review of Resident #1's Speech Therapist assessment dated November 11, 2006 on June 19, 2006 at approximately 1:10PM revealed a recommendation to monitor resident for rapid eating at mealtime. There was no evidence of training on the signs and symptoms of aspiration. b. Observation of the dinner meal on June 18, 2007 at approximately 6:15PM revealed that the resident's one to one had to give him verbal prompts to slow down his eating pace. Further observation revealed that the resident did comply and slowed down his eating pace. Review of staff training records on June 19, 2007 at approximately 1:15PM revealed no evidence that staff received training to address the signs and symptoms of aspiration. Review of Resident #2's Speech Therapist assessment dated October 14, 2006 ~~on June 19~~, 2006 at approximately 10:54AM revealed a recommendation to monitor resident for rapid eating at mealtime. There was no evidence of training on the signs and symptoms of aspiration. c. Observation of the dinner meal on June 18, 2007 at approximately 6:15PM revealed that the resident had to given verbal prompts to slow down his eating pace. Further observation	I 395	I 395 (e) Nursing **#9 (a - c): Signs and symptoms of aspiration training was conducted on: 06-27-2007. This is an annual training covered by nursing, speech and nutrition.**	06-27-2007

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I 395	Continued From page 14 revealed that the resident did comply and slowed down his eating pace. Review of staff training records on June 19, 2007 at approximately 1:15PM revealed no evidence that staff received training to address signs and symptoms of aspiration. Review of Resident #3's Speech Therapist assessment dated May 28, 2006 on June 19, 2006 at approximately 9:50AM revealed a recommendation to monitor the residentfor rapid eating. There was no evidence of training on the signs and symptoms of aspiration.	I 395		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that medication administered for behavior management does not interfere with the daily living activities for one of three residents in the sample. (Resident #1). The finding includes: 1. Observation of Resident #1 on June 19, 2007 approximately between 12:45PM- 2:30PM revealed that Resident #1 appeared to be drifting in and out of sleep during that period of time as he laid on the couch in the living room. Further observation revealed that with several physical/verbal prompts the client was able to get up and go to the bathroom with his one to one staff member. Interview with the Administrator on	I 401		

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I 401	Continued From page 15 June 19, 2007 at approximately 2:15PM revealed that they did not want to awaken the client because the facility wanted the psychiatrist to observe how Resident #1 was excessively sleeping when he came to the psychotropic review meeting that was scheduled that day. There was no documented evidence to substantiate that medication administered did not interfere with the resident's daily living activities. [Note: The psychiatrist did not come to the facility for the planned psychotropic review meeting on June 19, 2007] 2. Cross refer to W332.1 and W331.1. Review of an unusual incident report dated June 20, 2007 at approximately 10:00AM revealed that Resident #1 was observed sleeping on the couch when LPN #2 arrived on duty for medication pass at approximately 7:45AM. Client #1 appeared too drowsy at the time of medication pass and morning medications were not administered (Topamax 300mg, Revia 50 mg, Thorazine 400mg and Clarinex 5mg by mouth). Client #1 was transported to the emergency room for evaluation of excessive sleepiness at 9:05AM. Interview with LPN #2 and review of the Medication Administration Record (MAR) on June 20, 2007 at approximately 10:15AM revealed that Resident #1 was administered Topamax 300mg, Revia ~~50 mg, Thora~~zine 400mg by mouth at 6:00PM and Klonopin 4 mg by mouth at bedtime on June 19, 2007. There was no documented evidence to substantiate that medication administered did not interfere with the resident's daily living activities. 3. Interview with the Director of the day program on June 21, 2007 at approximately 11:45 AM, revealed that on November 1, 2006 and on	I 401	I 401 3520.3 Profession Services: General Provisions #1 - 2: Resident #1 was actively being medically evaluated for the sedated behavior which began prior to the survey date by his primary physician after the neurologist introduced a new medication to Resident #1's drug regime. The suspected offending drug was held pending further evaluation and follow up. Once it was determined that there were no other pathology contributing to his level of drowsiness, medications were adjusted further at the psychotropic medication review on 07-17-07 by the psychiatrist. As per policy, monitoring of the side effects of psychotropic medications shall be on-going occurring every six months, utilizing the MOSES form. The MOSES shall be reviewed by the prescribing psychiatrist. The psychotropic medication review team will completely document all observed and reported side effects of medications, and, the team's recommended actions on the meeting review sheet.	07-20-2007

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I 401	Continued From page 16 November 20, 2006 the facility was informed that Client#1 was observed to sleep from the time he arrived at the day program until around lunch time (11:00 AM-11:30 AM) and sometimes would fall asleep while eating his lunch. Further interview revealed that Resident #1 last attended day program on June 7, 2007 and will need to be medically cleared before returning to the day program. Review of a psychotropic review document dated November 20, 2006 on June 20, 2007 at approximately 1:35PM revealed that "some sedation reported by day program". Further review psychotropic review document revealed that Topamax 400mg twice a day by mouth was decreased to Topamax 300mg twice a day by mouth. [Note: The Primary Care Physician (PCP) has not medically cleared Resident #1 to attend the day program] 4. Interview with LPN #2 and review of an AIMS assessment dated December 18, 2006 on June 20, 2007 at approximately 1:40 PM revealed that Thorazine dosage was increased on December 19, 2006 and that the day program stated that the client was sleeping for two hours after arriving at the day program and was not able to do programs. Review of a psychotropic review document dated December 19, 2006, on June 20, 2007 ~~at approximately~~ 1:45PM revealed that target behaviors are stable but need to be of lower frequency, Thorazine 300mg twice a day by mouth was increased to Thorazine 400mg twice a day by mouth. There was no documented evidence to substantiate that medication administered did not interfere with the resident's daily living activities.	I 401	I 401 3520.3 Profession Services: General Provisions #3: Resident #1 was actively being medically evaluated for the sedated behavior which began prior to the survey date by his primary physician after the neurologist introduced a new medication to Resident #1's drug regime. The suspected offending drug was held pending further evaluation and follow up. Once it was determined that there were no other pathology contributing to his level of drowsiness, medications were adjusted further at the psychotropic medication review on 07-17-07 by the psychiatrist. The PCP released resident #1 to return to day program activities effective 07-16-2007. #4: The monitoring of the side effects of psychotropic medications shall be on-going occurring every six months, utilizing the MOSES form. The MOSES shall be reviewed by the prescribing psychiatrist. The psychotropic medication review team will completely document all observed and reported side effects of medications, and, the team's recommended actions on the meeting review sheet.	07-16-2007 07-20-2007

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I 401	Continued From page 17 5. Interview with LPN #2 and review of a nursing progress note dated May 15, 2007 on June 20, 2007 at approximately 1:50PM revealed that Resident #1's father who is his legal medical surrogate decision maker had concerns regarding the client's side effects from the psychotropic medications administered to manage his targeted behaviors. Review of a psychotropic review dated May 15, 2007, on June 20, 2007 at approximately 1:55 PM revealed "some improvement ". Further review of the psychotropic review document revealed that in the side effects columns "none" was noted besides all of the psychotropic medications prescribed. There was no documented evidence to substantiate that medication administered did not interfere with the clients' daily living activities.	I 401	I 401 **#5: The psychotropic medication review team will completely document all observed and reported side effects of medications, all concerned parties' comments & observations, and, the team's recommended actions on the meeting review sheet. Medication reviews shall be continued to be conducted monthly.**	07-20-2007
I 430	3521.7(a) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (a) Eating and drinking (including table manners, use of adaptive equipment, and use of appropriate utensils); This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that clients owned and/or consistently utilized prescribed adaptive equipment, for two of three residents in the sample. (Resident #1 and Resident #3) The findings include: 1. Dinner observation on June 18, 2007 at approximately 6:05 PM revealed that Resident #1 was using a bulit-up handled teaspoon in his right	I 430		

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I 430	Continued From page 18 hand to eat his prescribed diet from a scoop plate. In an interview with the client's one to one on June 18, 2007 at approximately 6:15 PM it was acknowledged that Resident #1 used a scoop plate instead of a plate guard during mealtime. Review of the OT assessment dated November 11, 2006 on June 19, 2007 at approximately 12:55 PM revealed a recommendation for Client #1 to utilize a plate guard. Review of the Individual Support Plan (ISP) dated November 14, 2006 on June 8, 2007 at approximately 12:45 PM revealed that it was recommended that Resident #1 utilize a plate guard during mealtime. There was no evidence that Resident #1 used a plate guard at mealtime as recommended by the ISP. 2. Observation during the lunch mealtime on June 18, 2007 at approximately 11:40 AM revealed that Resident #3 was served his prescribed diet in a divided plate and he was holding a built-up angled spoon in his right hand. Further observation revealed that Resident#3 coughed twice when drinking from the paper cup. In an interview with the day program staff on June 18, 2007 at approximately 11:50 PM it was acknowledged that Resident #3 used a paper cup instead of an opened handled spout mug during mealtime. Further interview revealed that Resident #3 did have an opened handled spout mug ~~to use~~ at the day program during mealtime. Review of the Individual Support Plan (ISP) dated June 13, 2006 on June 19, 2007 at approximately 9:25 AM revealed that it was recommended that Resident #3 utilize an opened handled spout mug during mealtime. Review of the Speech Therapist assessment dated May 28, 2006 on June 19, 2007 at approximately 9:50AM revealed a recommendation to monitor client for rapid eating. There was no evidence that	I 430	In response to 1430(1-2), the facility says as follows: 1. Although the purpose of the use of a plate guard is to prevent spillage and a scoop plate also prevents spillage, the direct care staff has been retrained to ensure that client #1 uses only plate guard during mealtime until the OT reviews the assessment. The QMRP and the Manager will aggressively monitor the staff to ensure consistent compliance with this protocol. 2. As further response to 1430, the facility say as follows: a. The Day Program was fully aware that client #3 uses an open handled spout mug. b. Client continues to use an →	6/27 /07 and ongoing 6/27 /07 and ongoing

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I 430	Continued From page 19 Resident #3 used an opened handled spout mug at mealtime as recommended by the ISP at the day program. 3. Observation during the dinner mealtime in the facility on June 18, 2007 at approximately 6:05 PM revealed that Resident #3 was served his prescribed diet in a divided plate and he was holding a built-up angled spoon in his right hand. Further observation revealed that Resident #3 coughed twice when drinking from a standard type cup. In an interview with the direct care staff on June 18, 2007 at approximately 6:12 PM it was acknowledged that Resident #3 used a standard cup instead of an opened handled spout mug during mealtime. Review of the Individual Support Plan (ISP) dated June 13, 2006 on June 19, 2007 at approximately 9:25 AM revealed that it was recommended that Resident #3 utilize an opened handled spout mug during mealtime. Review of the Speech Therapist assessment dated May 28, 2006 on June 19, 2006 at approximately 9:50AM revealed a recommendation to monitor client for rapid eating. There was no evidence that Resident #3 used an opened handled spout mug at mealtime as recommended by the ISP.	I 430	open handled spout mug in the day program. The QMRP will further have a case conference the day program to ensure that there is no repeat of the deficiency and or other concerns. 3. As further response to 1430, the facility says the direct care staff has been in serviced to ensure that client # 3 and other individuals being served use the appropriate and recommended adaptive equipments during mealtime. The QMRP and the House Manager will monitor the staff to ensure full compliance with the mealtime protocol for all the individuals being served in the facility.	7/26/07 6/27/07 and ongoing 6/27/07 and ongoing
I 431	3521.7(b) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (b) Toileting (including use of equipment); This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that clients owned and/or consistently utilized prescribed	I 431		

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I 431	Continued From page 20 adaptive equipment, for one of three clients in the sample. (Resident #3) The finding includes: During an environmental observation of all client areas on June 19, 2007 at approximately 10:00AM revealed that there was not a shower chair in the facility for Resident #3 to utilize during bathtime. In an interview with the QMRP on June 19, 2007 at approximately 10:15 AM it was acknowledged that Resident #3 did not have a shower chair. Review of Resident #3's OT assessment dated May 20, 2006, at approximately 10:30AM on June 19, 2007 revealed a recommendation that the client have a shower chair. There was no evidence that the Resident #3 had a a shower chair as recommended by the OT.	I 431	I 431 3521.7 (b) Habilitation and Training (b) Toileting (including use of equipment): Resident #3 has the use of a built-in shower bench, making an additional shower chair redundant, and reducing bathing space. Prior to the home's relocation to this facility, a shower chair was utilized, and then discarded after our move. The purpose of using a "shower chair" is for the person to sit safely while bathing; the shower bench facilitates this purpose.	01-26-2007
I 442	3521.7(l) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (l) Time management (including use of leisure time, scheduling activities); This Statute is not met as evidenced by: ~~Based on observation, interview~~ and record review, the facility failed to ensure the clients' right to be taught to manage their financial affairs to the extent of their capabilities for one of three clients in the sample. (Resident #3) The finding includes: Interview with the Qualified Mental Retardation	I 442	As a response to 1442, the facility says as follows: a. Client # 3 has received a comprehensive money management assessment. b. The QMRP will ensure effective implementation of any program based on the assessment for client #3. c. Aggressive quality assurance will be provided henceforth to ensure that client # 3 and other individuals being served receive money management assessments timorously to ensure continuous protection of the rights of the individuals to manage their financial affairs to best of their capabilities.	7/10/07 ongoing 7/10/07 and ongoing

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I 442	Continued From page 21 Professional (QMRP) on June 19, 2007 at approximately 4:15PM revealed that Resident #3 had not received a comprehensive money management assessment that outlined his current skills and specific needs in this area. Review of Resident #3's Individual Support Plan (ISP) dated June 13, 2006, at approximately 4:20PM on April 19, 2007 confirmed the QMRP's statement. There was no evidence that Resident #3 was taught to manage his finances to the extent of his capability.	I 442		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, and interviews the facility failed to demonstrate how the rights of all clients were protected and failed to allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States for six of six residents in the facility. The finding includes: During the survey conducted June 18-20, 2007, there was a voice alarm that rang each time one of the exit doors was opened. Interview with the Administrator on June 19, 2007 at approximately at 3:00 PM revealed that the door voice alarm was to prevent intruders from entering the facility. Further interview revealed that the door voice alarm system had not been approved by the Human Rights Committee (HRC).	I 500	I 500 3523.1 Resident Rights The non-commercial security system in the home does have the optional ability to announce an exterior door opening. This feature will be presented during the next scheduled HRC meeting as requested.	08-03-2007

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